



**Immediately notify
DOH Communicable
Disease Epidemiology
Phone: 877-539-5344**

Paralytic Shellfish Poisoning

County _____

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Other: _____
Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ Confirmed
☐ Probable
☐ No count; reason: _____

REPORT SOURCE

Initial report date ____/____/____
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know
Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____ Birth date ____/____/____ Age _____
Address _____ ☐ Homeless
City/State/Zip _____ Gender ☐ F ☐ M ☐ Other ☐ Unk
Phone(s)/Email _____ Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Phone: _____ Race (check all that apply)
Occupation/grade _____ ☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other
Employer/worksite _____ School/child care name _____

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

- ☐ ☐ ☐ ☐ Mouth tingling or numbness
☐ ☐ ☐ ☐ Breathing difficulty or shortness of breath
☐ ☐ ☐ ☐ Weakness
☐ ☐ ☐ ☐ Extremities numb
☐ ☐ ☐ ☐ Swallowing or speech difficulty
☐ ☐ ☐ ☐ Eyelids drooping (ptosis)
☐ ☐ ☐ ☐ Vision blurred or double
☐ ☐ ☐ ☐ Nausea
☐ ☐ ☐ ☐ Vomiting
☐ ☐ ☐ ☐ Diarrhea Maximum # of stools in 24 hours: _____

Clinical Findings

Y N DK NA

- ☐ ☐ ☐ ☐ Ataxia
☐ ☐ ☐ ☐ Cranial nerve abnormalities (bulbar weakness)
☐ ☐ ☐ ☐ Paralysis or weakness
☐ Acute flaccid paralysis ☐ Asymmetric
☐ Symmetric ☐ Ascending ☐ Descending
☐ ☐ ☐ ☐ Respiratory distress
☐ ☐ ☐ ☐ Respiratory failure
☐ ☐ ☐ ☐ Confusion
☐ ☐ ☐ ☐ Admitted to intensive care unit
☐ ☐ ☐ ☐ Mechanical ventilation or intubation required during hospitalization

Hospitalization

Y N DK NA

- ☐ ☐ ☐ ☐ Hospitalized for this illness
Hospital name _____
Admit date ____/____/____ Discharge date ____/____/____
Y N DK NA
☐ ☐ ☐ ☐ Died from illness Death date ____/____/____
☐ ☐ ☐ ☐ Autopsy

Laboratory

Collection date ____/____/____

Y N DK NA

- ☐ ☐ ☐ ☐ High levels of dinoflagellates associated with shellfish poisoning in water from which epidemiologically implicated shellfish were gathered
☐ ☐ ☐ ☐ Saxitoxin identified in epidemiologically implicated food
☐ ☐ ☐ ☐ Food specimen submitted for testing

NOTES

INFECTION TIMELINE

Enter onset date/time
(first sx) in heavy
box. Count backward
to figure probable
exposure period

Hours from
onset:

Exposure period

-4

-1

o
n
s
e
t

Calendar dates/times:

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or
outside of usual routine

Out of: ☐ County ☐ State ☐ Country

Dates/Locations: _____

Y N DK NA

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**

Y N DK NA

☐ ☐ ☐ ☐ **Shellfish or seafood**

County or location shellfish collected: _____

☐ ☐ ☐ ☐ Known contaminated food product

☐ ☐ ☐ ☐ Food from restaurants

Restaurant name/location: _____

☐ Patient could not be interviewed

☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Notify others sharing exposure

☐ Notify shellfish program

☐ Initiate trace-back investigation

☐ Other, specify: _____

NOTES

Investigator _____

Investigation complete date ____/____/____

Local health jurisdiction _____